DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445126 | A. BUILDING _____ B. WING _____ | 04/15/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| NHC HEALTHCARE, SEQUATCHIE | 360 DELL TRAIL, PO BOX 878 DUNLAP, TN 37327 |

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| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation and interview, the facility failed to revise the comprehensive care plan for two residents (#4, #5) of twenty one residents reviewed.<br><br>The findings included:<br><br>Resident #4 was admitted to the facility on June 30, 2009, with diagnoses including Pressure Ulcers, Type 2 Diabetes and Paraplegia. Review of medical record revealed admission weight documented at 222 pounds. Review of the facility weight record revealed the March 25, 2010, | F 279 | The Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied.<br><br>1. Resident #4 has multi-disciplinary interventions in place in care plan regarding weight gain as of 4/14/10 which included: Registered Dietitian to educate resident to select low calorie snacks between meals, all staff to discourage high calorie snacks and beverages, activity personnel to encourage resident to participate in activities including ball toss, parachute and sports challenge.<br><br>2. All residents will be assessed for weight gain and interventions placed in care plan as indicated.<br><br>3. The Dietitian and/or Food Service Director will monitor weights of all residents weekly and direct plans of care accordingly. | 5/15/10 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nurse Manager | TITLE: Administrator | (X6) DATE: 4-26-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 279 | Continued From page 1<br>weight documented at 247 pounds. Further review revealed an average gain of two to four pounds each month with a twenty four pound total weight gain in nine months since admission. Record review of the dietary progress notes revealed weight gain identified on March 24, 2010. Record review of the comprehensive care plan dated July 20, 2009, and dated as reviewed on October 13, 2009, January 2010 and April 1, 2010, revealed no interventions were put in place for the continued weight gain.<br><br>Interview with the Dietitian, the Dietary Manager and the Minimum Data Set Coordinator on April 13, 2010, at 1:30 p.m. at station one confirmed the the facility failed to identify weight gain as a problem and failed to care plan specific, individualized approaches to prevent further weight gain.<br><br>Resident #5 was admitted to the facility on June 18, 2008, with diagnoses including Alzheimer's Disease, Arthritis and Hypothyroidism.<br><br>Medical record review of a Post Fall Nursing Assessment dated December 4, 2009, revealed "...resident was seen falling straight from wheelchair and onto floor." Continued review of the medical record revealed, "...evaluate for proper seating..." Medical record review of an assessment dated December 7, 2009, revealed "...will change from wc (wheelchair) to rocking rolling recliner..." Medical record review of the current care plan revealed no documentation the care plan had been revised to include a rocking rolling recliner chair as an intervention to prevent falls.<br><br>Observation on April 13, 2010, at 8:35 a.m. and | F 279 | 4. The Food Service Director will report monthly to the Quality Assurance Committee on all significant weight changes.<br><br>1. The care plan of Resident #5 has been revised to reflect use of rocking rolling recliner to prevent fall.<br><br>2. The care plans of all residents using rocking rolling recliners as fall prevention interventions will be reviewed to assure appropriate plan of care is followed.<br><br>3. The Director of Nursing or designee will review all new residents requiring rocking rolling recliner as fall prevention intervention and assure care plan is correct and care is given appropriately.<br><br>4. The Director of Nursing will review all new fall prevention interventions and care plan revisions on an ongoing basis and direct care plan coordinators as needed. | 5/15/10 |

PRINTED: 04/15/2010
FORM APPROVED
OMB NO. 0938-0391

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| F 279 | Continued From page 2<br>10:00 a.m. in the 700 hall dayroom, revealed the resident in a rocking rolling recliner chair.<br><br>Interview on April 13, 2010, at 12:15 p.m., with Registered Nurse #1 in the 700 hall activity room confirmed the facility failed to revise the care plan to include the rocking rolling recliner chair. | F 279 | | |
| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and interview the facility delayed in treating one resident (#12) for recurrent Urinary Tract Infection of twenty-one residents reviewed.<br><br>The findings included:<br><br>Medical record review revealed resident #12 was admitted to the facility in May 2006, with diagnoses including Alzheimer's Dementia and Embolic Disorder. Record review of the Minimum Data Set, with a reference date of December 3, 2009, revealed the resident had a Urinary Tract Infection during the previous thirty days. Medical record review revealed from September 29, 2009, until October 6, 2009, the resident was hospitalized for a Urinary Tract Infection and Pneumonia.<br><br>Record review of the Nurse's Notes for February 4, 2010, at 5:00 a.m., revealed, "Urine obtained via straight cath (by a catheter being introduced into the bladder) without resistance." Record | F 281 | 1. Resident #12 has been treated for urinary tract infection from 2/10/10 through 2/20/10 with ampicillin 500mg qid, po.<br><br>2. All urinary laboratory reports showing infections will be reported to the physician when received from the laboratory. Follow-up with physician will be attempted each shift. If there is no response from the attending physician after 24 hours, the Director of Nursing or designee will contact the Medical Director for action regarding laboratory report.<br><br>3. Inservice will be held with all physicians and licensed nursing staff to emphasize the importance of getting laboratory reports to the physicians in a timely manner and appropriate timely follow-up by the physician. | |

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| F 281 | Continued From page 3<br>review of the Nurse's Notes six days later, on February 10, 2010, revealed initiation of nursing interventions and treatments and an antibiotic to treat the resident for a Urinary Tract Infection. Medical record review of the resident's laboratory results revealed the culture and sensitivity report for the submitted urine specimen (indicating the resident had a UTI) was reported back to the facility on February 7, 2010.<br><br>Observation of the secured unit on April 13, 2010, from 8:00 a.m. to 10:00 a.m., revealed the resident in the dining room, and after breakfast, in the dayroom scooting about in a wheel chair.<br><br>Interview at 3:50 p.m., on April 13, 2010, in the Director of Nursing office, with RN (registered nurse) #1, verified the nursing staff had suspected a recurrent Urinary Tract Infection from February 4, 2010, but did not initiate the nursing intervention and treatment until February 10, 2010. Interview continued and confirmed the nursing staff did not follow up with the physician when the facility did not receive a response to the lab results faxed to the physician's office on the evening of February 7, 2010, and an antibiotic was not started until the afternoon of February 10, 2010, resulting in a delay in treatment. | F 281 | 4. The Director of Nursing or designee will monitor all residents with infections to assure timely treatment and report any problems to the Quality Assurance Committee monthly. | 5/15/10 |
| F 312 SS=D | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This REQUIREMENT is not met as evidenced | F 312 | | |

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| F 312 | Continued From page 4<br>by:<br>Based on medical record review, facility policy review, observation, and interview, the facility failed to provide personal hygiene for one (#9) of twenty-one residents reviewed.<br><br>The findings included:<br><br>Resident #9 was admitted to the facility on July 2, 2008, with diagnoses including Traumatic Brain Injury, Diabetes, Hypertension, and Dementia.<br><br>Medical record review of the Minimum Data Set dated January 20, 2010, revealed the resident had short/long term memory problems, severely impaired cognitive skills for daily decision making, and was totally dependent for personal hygiene and bathing.<br><br>Medical record review of the care plan dated January 26, 2010, revealed, "...Toenails to be trimmed by licensed nurse or podiatrist..."<br><br>Review of the facility policy, Nail Care, revealed, "...All residents will be monitored routinely to assure nails are clean and appropriately trimmed ...Those residents suffering from immobility of fingers and or hands should have special care given to the inside palm of hands and between fingers...Special care is needed to assure the hand is completely dry and hand rolls or other adaptive equipment are applied..."<br><br>Observation on April 12, 2010, at 10:50 a.m., in the resident's room, revealed the resident lying on the bed with both feet uncovered. Further observation revealed the resident's toenails on both feet extended approximately ¼ inch beyond the nail bed. | F 312 | 1. Resident #9 has neatly trimmed toenails on 4/14/10 by staff nurse.<br><br>2. All residents will be assessed for toenails that need to be trimmed.<br><br>3. An inservice will be held with all nursing staff regarding the importance of toenail care and the procedure for referral to podiatrist if indicated.<br><br>4. All staff nurses will monitor all residents regarding toenail care every shift.<br><br>Any issues the staff nurse is unable to resolve will be reported to the immediate supervisor and ultimately to the Director of Nursing for resolution as needed. | 5/15/10 |

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| F 312 | Continued From page 5<br><br>Observation on April 12, 2010, at 3:55 p.m., in the resident's room, revealed the resident lying on the bed. Further observation revealed the left hand was contracted without a roll or other adaptive equipment in the hand.<br><br>Observation on April 13, 2010, at 10:30 a.m., in the resident's room, revealed the resident lying on the bed. Further observation revealed the left hand was contracted without a roll or adaptive equipment in the hand.<br><br>Observation on April 13, 2010, at 2:00 p.m., in the resident's room, with LPN #2, revealed the resident lying on the bed. Observation revealed an odor from the resident's contracted left hand when opened by LPN #2. Further observation with LPN #2 revealed the resident's toenails on both feet extended approximately ¼ inch beyond the nail bed.<br><br>Interview on April 13, 2010, at 2:00 p.m., in the resident's room, with LPN #2, confirmed the resident's left hand had an odor and the toenails needed to be trimmed. | F 312 | 1. Resident #9 has hand clean with no odor and adaptive roll in place on 4/14/10. As of 4/14/10, Range of Motion to contracted left hand is performed each shift during cleaning and through drying of affected hand.<br><br>2. All residents with a contracture will be assessed for hygiene, applicable adaptive equipment and need for daily range of motion of affected area of the body.<br><br>3. An inservice will be held with the nursing staff stressing the importance of range of motion and hygiene for contracted areas of the body as well as the use of different types of adaptive equipment. | |
| F 318 SS=D | 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>This REQUIREMENT is not met as evidenced | F 318 | 4. All staff nurses will monitor all residents with contracture every shift to assure proper hygiene and adaptive equipment is in place.<br><br>Any issues the staff nurse is unable to resolve will be reported to the immediate supervisor and ultimately to the Director of Nursing for resolution as needed. | 5/15/10 |

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| F 318 | Continued From page 6<br>by:<br>Based on medical record review, facility policy review, observation, and interview, the facility failed to ensure range of motion (ROM) was provided for one (#6) of twenty-one residents reviewed.<br><br>The findings included:<br><br>Resident #6 was admitted to the facility on August 7, 2009, with diagnoses including Contracture of Joint Hand, Traumatic Brain Injury, Paraplegia, Seizure Disorder, and Hypertension.<br><br>Medical record review of the Minimum Data Set (MDS) dated January 28, 2010, revealed the resident had moderately impaired cognitive skills, was dependent for all activities of daily living, and had limitation in range of motion (ROM) of the hands.<br><br>Medical record review of the Complete Patient Care Plan dated February 4, 2010, revealed no interventions/approaches to address the resident's limitation in ROM of the hands.<br><br>Observation on April 13, 2010, at 7:20 a.m., revealed the resident seated in the wheelchair, in the dining room, feeding self breakfast with the left hand. Continued observation revealed the resident's right hand was in a fisted position and there was no rolled washcloth/adaptive equipment placed in the resident's right hand.<br><br>Observation on April 13, 2010, at 9:35 a.m., 10:40 a.m., and 12:05 p.m., revealed the resident lying on the bed with the right hand in a fisted position without a rolled washcloth/adaptive equipment applied to the right hand. | F 318 | 1. Resident #6 has adaptive roll in use in contracted right hand and is reflected in care plan as of 4/14/10.<br><br>2. All residents with a contracture will be assessed for applicable adaptive equipment.<br><br>3. An inservice will be held with the nursing staff stressing the importance of the use of different types of adaptive equipment for residents with any type of contracture.<br><br>4. All staff nurses will monitor all residents with contracture every shift to assure care planned adaptive equipment is in place.<br><br>Any issues the staff nurse is unable to resolve will be reported to the immediate supervisor and ultimately to the Director of Nursing for resolution as needed. | 5/15/10 |

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| F 318 | Continued From page 7<br><br>Review of the facility's policy Nail Care revealed "...Those residents suffering from immobility of fingers and or hands should have special care given to the inside palm of hands and between fingers. This will aid in preventing skin breakdown and further immobility. Special care is needed to assure the hand is completely dry and hand rolls or other adaptive equipment are applied."<br><br>Observation on April 13, 2010, at 2:05 p.m., with Licensed Practical Nurse (LPN) #1, in the resident's room, revealed the resident lying on the bed with the right hand in a fisted position without a rolled washcloth or adaptive equipment applied to the right hand. Continued observation revealed LPN #1 extended the fingers of the right hand and an odor was noted and described by LPN #1 as sweaty. Observation of the resident's right palm revealed no skin breakdown.<br><br>Interview on April 13, 2010, at 2:00 p.m., with Certified Nursing Assistant (CNA) #1, (CNA responsible for the resident's care), in the hallway, confirmed CNA #1 had not provided hand care or ROM to the resident's right hand on April 13, 2010.<br><br>Interview on April 13, 2010, at 3:25 p.m., with the Director of Nursing, in the conference room, revealed the Certified Nursing Assistants were to provide ROM during the washing of the contracted hand, a hand roll or adaptive equipment was to be placed in the contracted hand, and confirmed the Complete Patient Care Plan did not address provision of care for the resident's contracted right hand. | F 318 | | |